ADOLESCENT SBIRT
Screening, Brief Intervention & Referral to Treatment
by NORC at the University of Chicago

Postvention in Healthcare Settings

Brett Harris, DrPH, Senior Research Scientist

Thursday, February 24th, 2022
Colorado Zero Suicide Learning Collaborative

As we begin today's session, please remember..

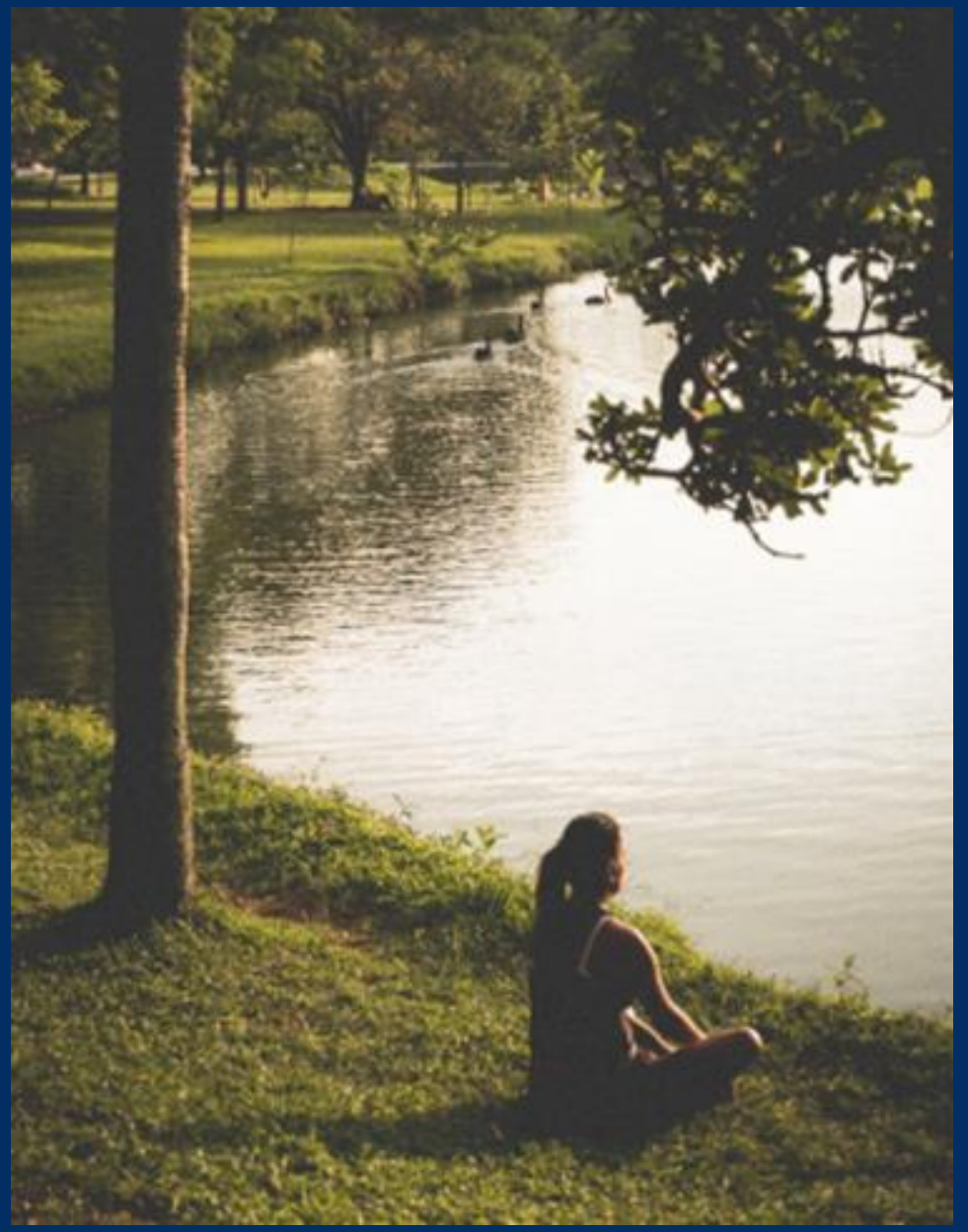
We all may have our own personal experiences with the topic of suicide.

Remember to take care of yourself first!

Resources are available for you:

- National Suicide Prevention Lifeline – 1-800-273-TALK (8255)
- Colorado Crisis Services – Text "TALK" to 38255 or call 1-844-493-8255
  https://coloradocrisisservices.org/

These numbers will give you 24/7 connection to a licensed counselor.



Discussion Questions for Participants:

How many agencies have been impacted by sudden losses (overdose, suicide, or both)?

What have the effects been on the agency, specifically staff members?

What do you hope to gain from this presentation?

Discussion Instructions:

1. Copy and paste the Menti link posted in the chat box into your internet browser OR your cell phone's internet browser https://www.menti.com/

2. Type in the code the following code: **2471 7045**

3. Now you are all set to answer the discussion questions! They will show as anonymous.

What is Postvention?

Grief after a suicide often involves guilt and shame in those left behind
- Traumatic for family/friends and can have a ripple effect on communities

As defined by Edwin Shneidman:
- Interventions for bereaved survivors, caregivers, and health care providers to:
  - Destigmatize suicide
  - Assist with the recovering process
  - Serve as a secondary prevention effort to minimize the risk of subsequent suicides due to complicated grief, contagion, or unresolved trauma

Timely, coordinated, and appropriate activities to provide support after a suicide and prevent future suicides
- Opportunity to educate the community about warning signs and how to help

Erlich MD et al. Why we need to enhance suicide postvention: Evaluating a survey of psychiatrists' behaviors after the suicide of a patient. *J Nerv Ment Dis*. 2017 July; 205(7): 507–511. doi:10.1097/NMD.0000000000000682.
California Mental Health Services Authority. After a rural suicide: A guide for coordinated community postvention response. 2016. https://www.cibhs.org/sites/main/files/file-attachments/after_rural_suicide_guide_2016rev.pdf

Postvention in Healthcare Settings

Most clinicians in the behavioral health field have lost patients to suicide

In a survey of psychiatrists by Erlich et al (2018):

- Half changed their practice patterns after a patient suicide
  - 1/3 sought increased supervision
  - 1/4 began using formal measures to assess suicidal thoughts and behaviors
  - 9.1% began using a formal postvention protocol or standardized toolkit
  - 9.8% stopped accepting patients they deemed at risk of suicide

Postvention interventions are rare, variable, and underutilized

Burden and risk of burnout

Lack of standardized approach in training and preparation for managing in the aftermath of a suicide

Erlich MD et al. Why we need to enhance suicide postvention: Evaluating a survey of psychiatrists' behaviors after the suicide of a patient. *J Nerv Ment Dis*. 2017 July; 205(7): 507–511. doi:10.1097/NMD.0000000000000682.

All healthcare settings should incorporate postvention as a component of a comprehensive approach to suicide prevention.

Grief and Loss


Image: pexel.com

Symptoms of Traumatic Loss

- Intrusive memories about the loss
- Avoidance and numbing towards loss
- Increased physiological arousal – irritation, anger, decreased sleeping
- Obsessive rumination regarding the loss
- Inability to shift focus
- Inability to find joy in life

Some suicides are misclassified as accidental overdose

- Ambiguous death may be particularly difficult and can result in more intense grief symptoms and unresolved grief over the long term

Clinician-Survivors

- Clinicians who have experienced the traumatic loss of a patient
  - ~15,000 new clinician survivors of suicide per year
- Often do not have outlets to acknowledge and address grief
- Having no "place" to mourn/lack of access to support, grief rituals
- Legal implications – fear of malpractice claim, Justice Center investigation, etc.
- Stigma in the field – seen as culpable for death, weak or "unprofessional" for grief
- Sense of responsibility – I was supposed to help them
- Disenfranchised grief - a loss that is not openly acknowledged, socially permitted, or publicly grieved

Traumatic Loss of Clients to Suicide

Approximately 1 in 5 psychotherapists lose a patient to suicide over the course of their career, and as many as 1 in 2 psychiatrists (source: American Association of Suicidology)

Losing a patient suddenly can be traumatic to the professional, and patient loss is a contributing factor to professionals leaving the field.

Typical Grief vs. Complicated Grief

Typical Grief

- Intense feelings begin to lessen over time
- Periods of intense sadness are normal, especially in the early months
- Able to eventually return to enjoyable relationships and activities
- Able to remember the deceased with less pain after a while
- Able to eventually reconcile and integrate the loss

Complicated Grief

- Intense and long-lasting feelings of longing for the deceased.
- Strong feelings of anger or bitterness
- Constant fear and anxiety
- Anhedonia – inability to enjoy things
- Complete avoidance of situations that may remind them of the grief
- Deep grief continues for years
- Inability to enjoy things
- Difficulty accepting the death
- Impairment in different functional areas, including personal relationships
- Can be debilitating in significant ways for years after the death

Grief Considerations for Clinicians

In addition to standard grief responses, clinicians may suffer increased feelings of:

- Helplessness
- Guilt
- A sense of responsibility for the death
- Diminished confidence
- Hypervigilance
- Mistrust of future clients
- Feelings of betrayal

Factors that can Impact the Grief Response

Professional

- Legal and regulatory environment
- Level of care (inpatient or outpatient)
- Duration and quality of the relationship to the client
- Agency reaction to patient loss (punitive versus supportive)
- Intensity and demands of job (overtime, on-call hours)
- Fear of contagion effect

Personal

- Past or current experience with death and trauma
- Beliefs about the role of clinicians in keeping patients alive
- Length of time in the field/educational or supervisory preparation for death and loss
- Hindsight bias

Clinical Implications- How does grief interfere with care?

There are a range of responses that can interfere with good care that range from:

Too much

- Hypervigilance for warning signs
- Overgeneralizing risk/seeing it everywhere
- Overworking oneself/taking on the most difficult cases
- Feeling overly responsible
- Using ones "heart" and having strong reactions
- Acting overzealous

Too little

- Feeling numb to clinical data
- Minimizing or missing risk
- Calling out sick, missing clinical notes, missing supervision
- Distancing and minimizing impact
- Being intellectualized and distant
- Feeling burned out

Working with Clinician Grief Overview

- Understand that grief is not something to be “fixed”
- Like other traumas, the loss of a person is integrated but not fully resolved
- Take into account the clinician’s developmental stage and background
- Acknowledge the enormity and intensity of the grief
- Understand that grief is not a uniform or predictable process

Role of Managers Following a Client Suicide

- Support to clinicians
- Manage own emotions
- Review death from ethical and regulatory standpoint
- Make programmatic changes
- Key players in developing and carrying out postvention plans

Postvention Considerations in Health Care Settings

Staff Debriefing

- Short and factual with those involved, soon after the suicide

Staff Support

- EAPs, trained trauma/grief therapists, bereavement time, local resources

Self-Care for Clinicians

- Morale-building activities, time off, limiting overtime, shared decision-making

Communicating with and Supporting Other Clients

Grief Assessments

Contact with Family Members/Supportive Others

Key Considerations for Administrators and Clinical Supervisors

- Normalize grief issues for staff and acknowledge the effect of client deaths on staff members and clients
- Reframe suicide prevention as a continuous and coordinated effort by all agency staff members
- Develop competencies through practice and teach-backs
- Help other managers develop clear protocols for traumatic loss prevention/postvention
- Train managers on proper procedures for staff debriefings and support following the suicide of a client, including how to provide a safe and supportive environment for clinician grief

Postvention Resources for Health Care Settings

Postvention Alliance (Colorado)- https://www.postvention.org/providers

Uniting for Suicide Postvention, Rocky Mountain MIRECC/CoE, US Dept. of Veterans Affairs- https://www.mirecc.va.gov/visn19/postvention/providers/content.asp#additionalResources

After a Suicide Loss, CO Office of Suicide Prevention- https://cdphe.colorado.gov/suicide-prevention/after-a-suicide-loss

Thank you!
Questions or comments?

Brett Harris, DrPH
Senior Research Scientist
NORC at the University of Chicago
Email: harris-brett@norc.org